Opening Statement of Hon. John Adler
7.22.2009
Committtee of Veterans Affairs: Oversight hearing "Enforcement of VA's Brachytherapy Program Safety Standards"

I would like to thank Chairman Filner, Chairman Mitchell, the House Veterans' Affairs Committee, and the Subcommittee on Oversight & Investigation for holding today's hearing on the VA's Brachytherapy Program Safety Standards. I would also like to thank our witnesses for agreeing to testify.

Our first President, George Washington, once said, "The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional as to how they perceive the Veterans of earlier wars were treated and appreciated by their country."

The veterans who sought treatment for prostate cancer at the Philadelphia VA Hospital did not receive the quality health care their selfless service to our country earned them. The people responsible for administering the substandard medical care in the brachytherapy program let our veterans down and sent the wrong message to young men and women thinking about joining our all-volunteer Armed Forces.

We are here today to evaluate the suspended brachytherapy program at the Philadelphia VA Hospital, which treated prostate cancer patients from 2002 until it was forced to close in June 2008, as well as to evaluate the VA's broader brachytherapy program safety standards.

News reports have depicted a rogue cancer unit and a rogue physician who botched nearly 80% of the procedures he was contracted to perform on our veterans. These multiple failures, which went undetected year after year, highlight significant problems in the VA's oversight system.

Recent newspaper articles highlight a prostate cancer treatment program that operated for more than 6 years with a glaring lack of oversight that should have been in place to protect our veterans. I am outraged that the brave men who so selflessly served our country have been subjected to such poor treatment and neglect by a hospital that was created to protect them.

I am further appalled that the routine safeguards that could have protected these veterans were either woefully inadequate or blatantly absent. Exposing our veterans to this type of mistreatment is not only unacceptable it violates the bond our country made with them when they agreed to fight for the safety and security of this nation. We must find and analyze the specific gaps in our system so that these failures never happen again.

What occurred at the Philadelphia VA's brachytherapy program is more than just one doctor's incompetence. The federal government failed on many levels to protect our veterans. The multi-pronged system currently in place to oversee radiation procedures across the country is not working. That is why the VA temporarily or permanently suspended other brachytherapy programs in Cincinnati, Ohio; Washington, DC; and Jackson, Mississippi.

This hearing is an opportunity to continue our investigations into the failures that have resulted in the forced closings of 4 out of 13 brachytherapy programs throughout the country. We must avoid a recurrence of this problem at all VA medical facilities.

This hearing is also an opportunity to begin examining the entire VA healthcare system. This is the start of an ongoing process to ensure that our veterans are receiving the high standard of medical care they deserve everywhere in the country.

I am looking forward to getting some answers from the VA today about what steps they are taking to ensure that the problems of the brachytherapy program in Philadelphia are not repeated elsewhere in the VA healthcare system. My hope is that the VA can give our veterans some confidence that the VA health system is providing the highest level of care.

Congress has an ongoing constitutional and moral responsibility to ensure that the Department of Veterans Affairs is providing the highest standard of care to our veterans. In that vein, I will be looking into legislative options that will strengthen the safeguards currently in place to protect our veterans from the kinds of mistakes and mistreatment that occurred in Philadelphia.

One of the options I will be considering is to require the VA to thoroughly evaluate whether the departments and programs currently operating at their medical facilities are meeting their safety standards and to periodically update Congress on their findings.

Additionally, I will be considering options where we can push the NRC to not only define the term "medical event" in their regulations, but also to set forth requirements concerning the training of medical personnel on what kind of situation constitutes a "medical event," to whom a medical event should be reported, and when the patient should be notified.

Lastly, I will be looking into legislatively requiring that post-implantation dose calculations are conducted on every patient of brachytherapy to ensure that the patient has received a dose of radiation that will effectively treat their prostate cancer.

We need to make sure we prevent this egregious mistreatment from happening again at the Philadelphia VA and at all VA hospitals across the country. If the VA cannot provide the proper oversight to protect its patients, then Congress will need to take action on our veterans' behalf. I look forward to getting started.